STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of the declaratory ruling request of Priority Health **Order No. 06-021-M**

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DECLARATORY RULING

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I
BACKGROUND

A. The Request for Declaratory Ruling

Priority Health, a Michigan-licensed health maintenance organization (HMO), requested a declaratory ruling on April 19, 2006 on a question it states as follows:

> Under the Michigan Small Employer Group Health Coverage Act, MCL 500.3701 *et seq.*, may a health maintenance organization require a minimum premium contribution level from the employer if the level is reasonable and applied uniformly?[1]

B. The Scope of this Declaratory Ruling

Section 63 of the Michigan Administrative Procedures Act of 1969,[2] authorizes agencies to issue declaratory rulings on request of an interested person and requires agencies to prescribe rules for the form, submission, consideration, and disposition of such requests. Pursuant to section 63, the Insurance Bureau[3] adopted administrative rules that require a person requesting a declaratory ruling to state all the known facts relevant to the determination and to identify the pertinent statutes and rules.[4] Moreover, the rules require that any declaratory ruling shall state that it is limited to the facts, statutes, and rules identified by the applicant or statutes or rules identified by the commissioner.[5]

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[1] Declaratory Ruling Request, p 1.

[2] MCL 24.263.

[3] Executive Order 2000-4 transferred all of the authority, powers, duties, functions, and responsibilities of the Insurance Bureau and of the Commissioner of Insurance to the Office of Financial and Insurance Services and the Commissioner of the Office of Financial and Insurance Services effective April 3, 2000.

[4] 1979 AC, R 500.1041.

[5] 1979 AC, R 500.1043(2).

These rules serve the common-sense purpose of making declaratory ruling requests manageable. This agency is not required to anticipate all possible statutory objections that might be raised to a course of action. Instead, the applicant must certify that it "has identified all statutes and rules which the applicant seeks to have considered by the commissioner in making the ruling."[6]

In conformity with these rules, this declaratory ruling is limited to those facts, statutes, and rules specifically identified by Priority Health in its Request for Declaratory Ruling and any other statutes or rules identified by the Commissioner in this declaratory ruling. The request identifies the following as the relevant statutes or rules:

- Chapter 37 of the Michigan Insurance Code, MCL 500.3701 *et seq.,* which regulates small employer group health coverage.
- Section 3519(1) of the Michigan Insurance Code, MCL 500.3519(1).[7]

C. Facts stated in the Request for Declaratory Ruling

Priority Health states that it is a nonprofit corporation licensed by the state as an HMO that offers health benefit plans to small employer groups. It asserts that HMOs and insurers have what it characterizes as a "longstanding practice" of requiring employers to make minimum contributions to the cost of health benefits plans covering their employees. Priority Health requires that an employer must pay either 75% of the single premium amount or 50% of the total premium amount, at the option of the employer. It states that it applies this requirement uniformly to all small employer group applicants

[6] 1979 AC, R 500.1041.
[7] Declaratory Ruling Request, p 4.

and that the requirements are "substantially below" the average amount that small employers are actually contributing in Michigan.

Priority Health asserts that minimum contribution requirements make employer-sponsored health care coverage relatively more affordable and therefore more attractive to employees. When employers contribute to the cost of coverage, other things being equal, more employees who are healthy tend to participate in the plans. Conversely, when employees are required to pay more of the cost of these plans, healthier employees are less likely to participate in the plans than less-healthy employees. This is a factor in what is known as "adverse selection," namely the tendency for persons who are less healthy than average to apply for and continue coverage. Because the group tends to be less healthy than average, the overall cost of the plan is higher than it would be if more healthy persons were covered. Priority Health asserts that minimum contribution requirements combat adverse selection by encouraging more healthy employees to participate in the plan, therefore allowing carriers to charge lower premiums on average.

Priority Health asserts that minimum participation requirements, which require that a minimum percentage of those employees seeking coverage through their employer must enroll in a plan, are ineffective in combating adverse selection where the employer offers only one health benefit plan. Priority Health asserts that employees who do not participate in employer-sponsored health plans often end up uninsured or rely on Medicaid.

II
ANALYSIS

A. At the time it was considering adding Chapter 37 to the Insurance Code, the Legislature noted serious problems with the market for small employer group health coverage. Premiums for small employer groups could rise dramatically due to the employees' health condition. This encouraged health carriers and employers to insure only the healthiest employees and effectively shunted high-risk employees and groups to Blue Cross and Blue Shield, whose rates were almost one-third higher.

Prior to the addition of Chapter 37 to the Insurance Code in 2003, the various entities writing health coverage for small employers did not compete on a level playing field due to differences in the statutes regulating them. These differences created incentives for employers and health carriers to manipulate the system in an effort to reduce the cost of employer-sponsored health care plans.

While the cost of providing commercial insurance for employer-sponsored health plans varied based on the health condition of covered employees, the variations were particularly acute for small employers because they could only spread the cost over a smaller number of employees. Even one sick employee could dramatically drive up the cost for a small employer plan. As the legislative analysis for the bill that became Chapter 37 notes: "In a small business with 20 workers, for example, one employee diagnosed with diabetes or cancer could cause the business owner's insurance premiums to triple the following year."[8] Thus employers seeking lower-cost coverage and their insurers had incentive to cover only the healthiest employees, a process known as "cherry

[8] Senate Fiscal Agency, Bill Analysis, Senate Bills 234, 238, and 460 (as enrolled) and House Bills 4280 and 4281 (as enrolled), September 17, 2003, p 1. A copy of this analysis is Attachment A to this declaratory ruling.

picking."[9] Conversely, commercial insurers had incentive to engage in "dumping," i.e., encouraging nonrenewal of high-risk groups. Although federal law restricted the ability of commercial insurers to unilaterally refuse to renew health policies, insurers could accomplish the same result by increasing the price for high-risk groups to such a level that the coverage was no longer attractive.[10]

As a result of cherry picking and dumping, many high-risk individuals and groups sought coverage from Blue Cross and Blue Shield, which, unlike commercial insurers, was required by law to insure all individual applicants despite their health status. Moreover, unlike commercial insurers, Blue Cross was required to set its group prices based on "community based rating." That means that Blue Cross was required to include both high-risk and low-risk people when setting its price. As a consequence of these differences, at the time Chapter 37 was before the Legislature, Blue Cross coverage cost an average of 30% more than coverage from commercial insurers. The legislative analysis for the bill that became Chapter 37 of the Insurance Code described the situation for small group coverage as follows:

> Reportedly, when commercial carriers raise their rates high enough, many Michigan employers turn to BCBSM for group coverage. Although not the insurer of last resort for groups, BCBSM does issue group policies, but is prohibited from using age, medical condition, claims experience, or other "case characteristics" to determine rates. Under the Nonprofit Health Care Corporation Reform Act, the State statute that governs BCBSM, the company must use "community based rating" to set its rates, which means that both low-risk and high-risk classes are factored into the rating, spreading the expected medical costs across the entire community. It is these restrictions on its pricing that, according to BCBSM, cause its rates actually to rise as the number of younger, healthier people leaves its

[9] Attachment A, p 1.
[10] Attachment A, p 1.

> risk pool for cheaper insurers, or abandon insurance altogether, because they cannot afford it. As they exit BCBSM's pool, it becomes older and sicker, and then rates rise for the community as a whole. Rates for small business insurance at BCBSM are currently, on average, 30% higher than the cost of commercial insurance.[11]

Although 47 states had adopted small group market reform based on a model act drafted by the National Association of Insurance Commissioners (NAIC), Michigan had not yet done so when Chapter 37 came before the Legislature in 2003.[12]

B. Chapter 37 requires small employer carriers to insure any small employer that applies for coverage, agrees to pay the premium, and satisfies other reasonable requirements of the plan not inconsistent with Chapter 37. It also restricts the way that carriers calculate the cost of the coverage, requires renewal except in specified circumstances, and adopts other restrictions designed to encourage employees to join the plan.

The Legislature adopted Chapter 37 in 2003 in an effort to resolve problems in the small employer market, especially dumping and cherry picking. To begin with, Chapter 37 requires every small employer carrier as a condition of doing business in Michigan[13] to make its plans available to all small employers. A small employer carrier must issue any health benefit plan it sells to any small employer that applies for the plan, agrees to pay the required premium, and agrees "to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter."[14] Moreover, small employer carriers must renew or continue the health benefit plan at the option of the small

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[11] Attachment A, p 1.

[12] Attachment A, p 2.

[13] "Carrier" includes commercial health insurance companies, Blue Cross, HMOs, multiple employer health welfare arrangements, and any other person offering health benefits subject to state insurance regulation. MCL 500.3701(d). "Small employer carrier" includes both carriers who offer health benefit plans for employees of a small employer (i.e., one with between 2 and 50 eligible employees) and carriers who provide a health benefit plan to a sole proprietor. MCL 500.3701(q).

[14] MCL 500.3707(1).

employer except in the following circumstances:

- Fraud or intentional misrepresentation of the small employer or an insured individual.
- Lack of payment.
- Noncompliance with minimum participation requirements.
- If the small employer carrier stops offering that particular type of coverage in the market.
- If the small employer moves outside the geographic area.[15]

In addition to requiring small employer carriers to issue and renew health benefit plans, Chapter 37 limits the factors these carriers may consider and how they may use these factors in setting the price of coverage. Carriers may have no more than 10 geographic rating areas in the state for health benefit plans covered by Chapter 37. Within these geographic areas, permissible rating factors vary depending on the type of carrier.

- Blue Cross may use only the type of industry and age.
- HMOs may use only the type of industry, age, and the size of the group.
- Commercial carriers may use only the type of industry, age, group size, and health status.[16]

These limitations tend to dampen the variation in rates that might otherwise occur. For example, carriers are not allowed to use gender as a rating factor even though women of child-bearing years may represent a significantly higher risk than males of the same age. As a result, any higher costs associated with gender are necessarily averaged across the entire rating pool.

Besides identifying the only allowable rating factors, Chapter 37 limits the amount that premiums may deviate from a health benefit plan's average rate, called the

[15] MCL 500.3711(2).
[16] MCL 500.3705(2)(a).

"index rate," in each geographic area.[17] The "index rate" is the arithmetic average of the highest and lowest premium charged per employee for each health benefit plan offered by each carrier in a geographic area.[18] Like the limitation on rating factors, this limitation also diminishes the permissible degree of variation in rates between lower and higher risks. Lower-risk groups may be charged a somewhat higher premium than their expected losses indicate and higher-risk groups may be charged a somewhat lower premium than their expected losses indicate in order to comply with this limitation. Capping the amount that premiums may vary from the index rate reflects a compromise between allowing carriers to freely rate groups based on their particular expected losses (sometimes called proportional risk rating) and requiring carriers to set rates based on the average expected losses for the entire pool of covered persons in a territory (sometimes called community rating).[19]

In addition to capping the degree to which premiums may vary from the average for each small employer health plan, Chapter 37 caps the percent increase in premium for any particular small employer in a new rating period depending in part on the change in

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[17] MCL 500.3705(2).

[18] MCL 500.3701(l).

[19] *Expanding Consumer Choice and Addressing "Adverse Selection" Concerns in Health Insurance,* Hearing Before the Joint Economic Committee, Congress of the United States, 108th Cong., 2d sess., 31 (2004)(Prepared statement of Mark V. Pauly, PhD., Bendheim Professor, Professor of Health Care Systems, Insurance and Risk Management and Business and Public Policy in the Wharton School, and Professor of Economics in the College of Arts and Sciences, University of Pennsylvania, subsequently referred to as: S. Hrg. 108-766, Pauly prepared testimony). The entire report is available on the internet at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_senate _hearings&docid=f:97228.pdf. A copy of Pauly's prepared statement, pp 30-39 of the report, is attached to this declaratory ruling as Attachment B.

the index rate for that geographic area.[20] These limitations work together to mitigate both large variations in premium among small employer plans and large swings in premiums for a particular small employer plan from one rating period to the next.

Chapter 37 also authorizes practices that encourage employees to participate in their employer-sponsored health benefit plan. These practices include:

- Minimum participation requirements—a small employer carrier may deny coverage to a small employer if less than a fixed percent of employees seeking coverage enrolls in the plan. For example, a carrier may deny coverage to an employer with between 11 and 25 employees if fewer than 75% of the employees seeking coverage through their employer enroll.[21]

- Limits on special enrollment periods—An eligible employee who fails to enroll when a plan is initially offered may not enroll during a special enrollment period for late enrollees unless he or she initially declined enrollment due to coverage under another group health plan and the other coverage has been exhausted or has terminated due to loss of eligibility. In other words, an employee who declines to join a plan when eligible to do so has limited ability to join the plan subsequently. This limitation on late enrollment encourages employees to enroll at the first opportunity.[22]

- Billing must be on a composite basis—Except for differences based on health benefit plan options, number of family members covered, and Medicare eligibility, a small employer carrier shall bill an employer on a composite basis. This means that, except as noted, no carrier may bill an employer so that any employee is charged a higher premium than any other employee in the small employer group. This helps to prevent targeting of high cost employees for exclusion from the group.[23]

- Guaranteed renewal—With limited exceptions, carriers must renew or continue coverage at the option of the employer. Coupled with the requirement of composite billing, guaranteed renewal encourages healthy employees to participate in the plan to protect themselves against future

[20] MCL 500.3705(2)(e).
[21] MCL 500.3709.
[22] MCL 500.3708.
[23] MCL 500.3705(5).

> premium increases resulting from the development of individual chronic illness.[24]

Taken together these provisions address the related problems of cherry picking and dumping. They require every small employer carrier to make all its plans available to all small employers and to renew the coverage at the employer's option. They limit the degree to which these carriers may vary costs based on the individual risk of persons in the plan. They limit a small employer carrier's ability to bill employers different premiums for different employees. They encourage all employees to participate in the plan.

C. Minimum employer contribution requirements are not permissible unless they are both reasonable and consistent with Chapter 37.

In an employer-sponsored health plan, the employer is responsible to make the payments to the carrier, whether the employer makes a financial contribution to the cost of the plan or simply collects the full cost from its employees. Under Chapter 37, small employer carriers may not require an employer to contribute a specified percentage of the cost of the plan, referred to as a minimum contribution requirement, unless this requirement is both reasonable and consistent with Chapter 37.

Under Chapter 37, in order to do business in Michigan, a small employer carrier must make available to each small employer all of the small employer health plans it markets to small employers in this state. If an employer applies for a plan and agrees to pay the premium, the carrier may only impose conditions that are both "reasonable" and "not inconsistent with" Chapter 37. Section 3707(1) provides:

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[24] MCL 500.3711.

> As a condition of transacting business in this state with small employers, every small employer carrier shall make available to small employers all health benefit plans it markets to small employers in this state. A small employer carrier shall be considered to be marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that small employer carrier. A small employer carrier shall issue any health benefit plan to any small employer that applies for the plan and agrees to make the required premium payments ***and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.***[25]

Section 3701(n) defines "premium" broadly to include all money paid for coverage, whether paid by the employer, the employees, or eligible persons:

> "Premium" means all money paid by a small employer, a sole proprietor, eligible employees, or eligible persons as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.[26]

Thus under section 3707(1), a carrier must make its health plans available to any small employer who applies for a plan and agrees to make the premium payments, subject only to reasonable conditions that are not inconsistent with Chapter 37. Under section 3701(n), premium means the total cost, no matter what its ultimate source. Indeed, section 3703(1) explicitly provides that Chapter 37 applies to: "***any*** health benefit plan that provides coverage to 2 or more employees of a small employer"[27] without differentiating between plans employers contribute to and those they do not contribute to. The question, then, is whether minimum employer contribution requirements are reasonable and consistent with Chapter 37. If not, then they are prohibited.

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[25] MCL 500.3707(1)(emphasis added).
[26] MCL 500.3701(n).
[27] MCL 500.3703(1) (emphasis added).

D. Minimum contribution requirements are prohibited because they are both unreasonable and inconsistent with the obligation of small employer carriers to renew or continue coverage at the option of the small employer.

Priority Health refuses to issue coverage subject to Chapter 37 unless an employer contributes a fixed percentage of the total cost. An employer must contribute either 75% of the single premium amount or 50% of the total premium amount, at the option of the employer.[28] Even if an employer and its employees agree between themselves on a different cost-sharing arrangement ***that covers the full cost of the coverage***, Priority Health will not issue the coverage unless the employer satisfies this minimum contribution requirement. Because it is both unreasonable and inconsistent with Chapter 37, Priority Health's minimum employer contribution requirement is prohibited.

In addition to requiring small employer carriers to initially make their health plans available to small employers, Chapter 37 requires these carriers to renew or continue the plans if the employer chooses to do so, except in certain explicitly identified circumstances. These circumstances do not include an employer's failure to comply with a minimum employer contribution requirement. Section 3711 provides:

> (1) Except as provided in this section, a small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan ***shall renew or continue in force that plan at the option of the small employer*** or sole proprietor.
> (2) ***Guaranteed renewal under subsection (1) is not required in cases of:*** fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by the insured individual or the insured individual's representative; lack of payment; noncompliance with minimum participation requirements; if the small employer carrier no longer offers that particular type of coverage in

[28] Declaratory Ruling Request, p 2, ¶ 5.

> the market; or if the sole proprietor or small employer moves outside the geographic area.[29]

If the Legislature had intended to permit carriers to deny renewal based on noncompliance with minimum contribution requirements, it would have included that as one of the exceptions in section 3711(2)—just as it included noncompliance with minimum participation requirements. But clearly it did not. Therefore, under section 3711(2) a carrier must renew coverage without regard to the level of an employer's contribution to the total cost of the plan.

Since Chapter 37 requires a carrier to renew coverage without regard to the level of an employer's contribution, Priority Health's minimum employer contribution requirement is not "reasonable" and is "inconsistent with" Chapter 37 as those terms are used in section 3707(1). Because these terms are not defined by Chapter 37, it is appropriate to consult dictionary definitions to interpret them.[30] "Reasonable" means "based on good sense."[31] "Inconsistent with" means "not compatible or in keeping with."[32] It is not reasonable to impose a minimum employer contribution requirement as a condition ***to initially obtain*** coverage because the carrier must ***renew*** the coverage despite an employer's decision to pay less than the carrier's minimum requirement. Similarly, it is inconsistent with the unambiguous obligation ***to renew coverage*** without regard to the employer's contribution level for a carrier ***to refuse to issue coverage at the outset*** on this same basis. Priority Health suggests no reason why the Legislature would

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[29] MCL 500.3711 (emphasis added).

[30] *E.g., Lakeland Neurocare Centers, v State Farm Mutual Automobile Insurance Company*, 250 Mich App 35, 40-41; 645 NW2d 59 (2002).

[31] *The New Oxford American Dictionary*, Second Edition (2005).

[32] *The New Oxford American Dictionary*, Second Edition (2005).

allow a minimum contribution requirement at the time coverage is issued, yet mandate renewal without regard to the employer's share. The two propositions are not compatible.

Priority Health argues that unless an employer contributes to the cost, the coverage "arguably is not group coverage at all" but is only a collection of individual policies.[33] But it cites no authority for this bare assertion and we know of none. To the contrary, in the context of group life insurance, the Insurance Code explicitly provides that the premium may be paid "by the employer, the employees, or by both the employer and the employees jointly . . . ."[34] Similarly, the Insurance Code defines group disability insurance without regard to who pays the premiums.[35] This certainly undermines Priority Health's argument that coverage is not group coverage if the employees pay all of the premium. But more to the point, Chapter 37 applies to "***any*** health benefit plan that provides coverage to 2 or more employees of a small employer," without reference to who pays the premium.[36] Priority Health's argument in this regard is both without support and contrary to existing law.

Because Priority Health's minimum contribution requirement is unreasonable and inconsistent with section 3711, it violates section 3707(1) and is prohibited.

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[33] Request for Declaratory Ruling, p 13.
[34] MCL 500.4404.
[35] MCL 500.3601.
[36] MCL 500.3703(1).

E. The Legislative history of the bill that became Chapter 37 confirms that Priority Health's minimum contribution requirement is unreasonable and inconsistent with Chapter 37 and therefore illegal.

Based solely on the language of Chapter 37, Priority Health's minimum contribution requirement is impermissible. It is unreasonable and inconsistent with the unambiguous statutory requirement that a carrier must renew or continue coverage regardless of the level of the employer's contribution. This alone is sufficient to answer the question presented by Priority Health without reference to other considerations. As the Michigan Supreme Court has noted: "When the legislative intent can be discerned from the express language of a statute, no further interpretation is warranted."[37] But the Legislative history confirms the conclusion dictated by the plain language of Chapter 37.

Chapter 37 evolved from Senate Bill No. 460, which was introduced in the Michigan Senate on May 7, 2003.[38] The Senate passed a substitute bill on May 28, 2003.[39] Under section 3711 of both of those bills,[40] small employer carriers were required to renew coverage without regard to the level of an employer's contribution. But the House passed a different version of the bill on June 5, 2003.[42] Like the two prior Senate versions, section 3711 of this House bill required guaranteed renewal except in

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[37] *Mutual Life Ins Co of New York v Insurance Bureau*, 424 Mich 656, 666; 384 NW2d 25 (1985).

[38] 2003 Journal of the Senate 527.

[39] 2003 Journal of the Senate 665-666 and 669-670.

[40] Senate Bill No. 460 as introduced in the Senate on May 7, 2003 and the substitute for Senate Bill No. 460 as it passed the Senate on May 28, 2003 are Attachments C and D respectively to this declaratory ruling.

[41] Senate Bill No. 460 as introduced in the Senate on May 7, 2003 and the substitute for Senate Bill No. 460 as it passed the Senate on May 28, 2003 are Attachments C and D respectively to this declaratory ruling.

[42] 2003 Journal of the House 745-748.

enumerated circumstances. Unlike the Senate versions, this House version ***expressly included*** noncompliance with minimum participation ***"or employer contribution"*** requirements among the permissible grounds for nonrenewal. The pertinent language of the House version read as follows:

> (2) Guaranteed renewal under subsection (1) is not required in cases of: fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative; lack of payment; noncompliance with minimum participation ***or employer contribution*** requirements; if the small employer carrier no longer offers that particular type of coverage in the market; or if the sole proprietor or small employer moves outside the geographic area.[43]

When the Senate refused to concur in the House-passed version, the matter was referred to a conference committee made up of members of both the Senate and the House.[44] The conference committee deleted the House language allowing nonrenewal for failure to comply with a minimum employer contribution requirement.[45] Both chambers adopted the conference report on June 25, 2003 and this version became law.[47]

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[43] The House substitute that passed the House on June 5, 2003 is Attachment E to this declaratory ruling. The quoted language appears on page 23 of that bill. Unlike Chapter 37, the Small Employer and Individual Health Insurance Availability Model Act adopted by the National Association of Insurance Commissioners explicitly allows nonrenewal on the basis of: "Noncompliance with the carrier's employer contribution requirements." NAIC Model Act, section 6(1)(d).

[44] 2003 Journal of the Senate 809, 836. 2003 Journal of the House 830.

[45] 2003 Journal of the Senate 1023, 1028. 2003 Journal of the House 1089, 1094.

[46] 2003 Journal of the Senate 1023-1031. 2003 Journal of the House 1089-1097. A three-page summary from the Legislature's web page tracking the course of this legislation through the Senate and House, complete with references to the pertinent pages of the House and Senate Journals is Attachment F to this declaratory ruling. The final version of Senate Bill No. 460, which became 2003 PA 88, is Attachment G to this declaratory ruling. The pertinent language appears on page 6 of that act.

[47] 2003 Journal of the Senate 1023-1031. 2003 Journal of the House 1089-1097. A three-page summary from the Legislature's web page tracking the course of this

If the Legislature had agreed on the version of section 3711 that allowed nonrenewal for failure to comply with employer contribution requirements, there would be no inconsistency between the guaranteed issue provisions of section 3707(1) and the guaranteed renewal provisions of section 3711(2). But both the House and the Senate rejected the language allowing nonrenewal based on noncompliance with employer contribution requirements. The Legislature's rejection of the proposed language is strong evidence of its intention to require renewal without regard to the level of an employer's contribution. In other cases in which the Legislature similarly rejected proposed language that, had it been enacted, would have supported a litigant's proposed statutory interpretation, our Supreme Court relied heavily on the Legislature's rejection stating: "We should not, without a clear and cogent reason to the contrary, give a statute a construction which the Legislature itself plainly refused to give"[48] Since both houses of the Legislature rejected the language allowing nonrenewal for failure to comply with minimum premium requirements, under section 3711(2) a carrier must renew coverage without regard to the level, if any, that an employer contributes to the cost of the employee benefit plan. Because Priority Health's employer contribution requirement is inconsistent with this guaranteed renewal provisions of section 3711(2), it is prohibited by section 3707(1).

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legislation through the Senate and House, complete with references to the pertinent pages of the House and Senate Journals is Attachment F to this declaratory ruling. The final version of Senate Bill No. 460, which became 2003 PA 88, is Attachment G to this declaratory ruling. The pertinent language appears on page 6 of that act.

[48] *People v Adamowski,* 340 Mich 422, 429; 65 NW2d 753 (1954). *Accord Wayne County v Auditor General,* 250 Mich 227, 235; 229 NW 911 (1930); *Miller v State Farm Mut Auto. Ins. Co*, 410 Mich 538, 567; 302 NW2d 537 (1981); and *Allstate Ins Co v Department of Ins*, 195 Mich App 538, 546; 491 NW2d 616 (1992).

F. It is up to the Legislature to balance the competing public policy considerations. The Legislature did just that in Chapter 37 by deciding which tools were necessary to deal with adverse selection and which were not. Priority Health's public policy arguments are appropriately made to the Legislature.

Priority Health devotes a substantial part of its declaratory ruling request to explaining the purported utility of minimum contribution requirements in combating adverse selection. But by focusing on this single factor, Priority Health fails to recognize that there are a variety of ways to combat adverse selection; that the Legislature explicitly required or allowed the use of some of them, but not minimum contribution requirements; and that it is the province of the Legislature to balance the benefits and costs of the available strategies to address the problems in the small employer group health market, including adverse selection.

Adverse selection results from the greater tendency of higher-risk individuals to seek insurance coverage compared to lower-risk persons. Obviously someone who expects to be sick and face high medical costs has greater incentive to seek health insurance than a similarly situated person who is healthy and does not expect costly health problems. Therefore the pool of insured persons tends to be sicker than the population as a whole. Because of this, covered losses, and hence the cost of coverage, are higher than they would be if more healthy persons were included in the pool. Priority Health argues that this adverse selection and the resulting higher costs cause lower risks to leave the group. The loss of the lower-risk persons in turn drives prices yet higher because on average the remaining members are sicker. More healthy members leave as the price goes up and the pattern continues. Priority Health argues that the resulting

"death spiral" increases the number of uninsured persons as more and more of the lower risks leave the insurance pool.[49]

Priority Health asserts that minimum contribution requirements reduce the likelihood of adverse selection by making coverage more affordable and therefore more attractive to employees. Healthier employees are less likely to leave the employer's health plan if the employer makes a substantial contribution to the cost of the plan, thus lowering the employees' out of pocket costs. As a result, they say, more people are insured, which is good public policy and consistent with the goals of Chapter 37.[50]

But Priority Health's argument that minimum contribution requirements fight adverse selection and therefore advance the goals of Chapter 37 fails to consider at least four countervailing facts.

- First, employer-sponsored group health insurance by its very nature tends to attract healthier individuals, thus mitigating adverse selection.
- Second, the Legislature incorporated into Chapter 37 several measures that tend to encourage healthier employees to participate in the plan, thus further mitigating adverse selection.
- Third, minimum contribution requirements come with a cost. They may in fact cause employers who wish to contribute less than the minimum percentage level demanded by carriers to cancel their coverage altogether.
- Fourth, the Legislature has the prerogative and the obligation to balance the competing advantages and costs associated with the various tools available to combat adverse selection. If the Legislature had intended to allow carriers to impose minimum contribution requirements, it would have explicitly so provided in Chapter 37—as it explicitly allowed other strategies, including minimum participation requirements, limited late enrollment, affiliation periods, limits on rating criteria, and guaranteed renewal.

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[49] Declaratory Ruling Request, pp 4-6. See also Exhibit R to Declaratory Ruling Request, "How Private Insurance Works: A Primer," p 4.

[50] Declaratory Ruling Request, pp 6-9 and 13-16.

1. By their very nature, employer-sponsored group insurance plans combat adverse selection.

Adverse selection results from the greater tendency of higher risk individuals to seek insurance coverage compared to lower risk persons. Accordingly, in the case of health insurance, the pool of insured persons tends to be sicker than the population as a whole. But by its very nature, employer-sponsored group health coverage mitigates this tendency for several reasons.

- First, unlike the pool of policyholders who seek individual health coverage, a group consisting of the employees in a particular business is not formed just for the purpose of purchasing health insurance. This reduces the likelihood that the group is disproportionately unhealthy.[51]

- Second, to join the employer's group, a person must be healthy enough to work. This automatically excludes people who are too sick to work and those unable to work because they are caring for dependents who are high risk.[52] Moreover, typically in order to qualify for coverage, an employee must work a minimum number of hours per week[53] and be employed by that employer for a minimum amount of time,[54] further tending to eliminate high-risk individuals who can't satisfy these requirements. Thus, employer-sponsored group health insurance automatically screens out some of the highest risk persons.

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[51] *See, e.g.*, Exhibit R to the Declaratory Ruling Request, "How Private Insurance Works: A Primer" p 6. ("The most efficient and effective underwriting mechanism for avoiding adverse selection is to provide coverage to already formed large groups of people, such as the employees of a large employer. In such cases, the health coverage provider knows that the individual members of the group did not join it primarily to get insurance, so there is a much lower chance that the group is composed disproportionately of people in poor heath.")

[52] *See, e.g.,* S. Hrg. 108-766, Pauly prepared testimony, p 35.

[53] To be an "eligible employee" under Chapter 37, a person must be a full-time employee with a normal workweek of 30 or more hours, except that an employer may elect to include full-time employees with a normal workweek of between 17.5 and 30 hours if this criterion is uniformly applied to all employees without regard to health status. MCL 500.3701(h).

[54] Section 3707(2) authorizes affiliation periods of up to 60 days for new enrollees and up to 90 days for late enrollees. MCL 500.3707(2).

- Third, there is a substantial tax subsidy to employees covered by an employer-sponsored group plan because compensation received in the form of health benefits is excluded from income and payroll taxes.[55]

- Finally, group policies have lower administrative costs than individual health policies, especially for marketing and billing. This cost advantage provides additional incentive for even lower-risk persons to participate in their employer's plan.[56]

Thus, employer-sponsored group health insurance plans have certain inherent characteristics that lessen the tendency toward adverse selection.

2. The Legislature incorporated multiple requirements and limitations into Chapter 37 that further mitigate adverse selection.

While employer-sponsored plans inherently tend to lessen adverse selection, the Legislature also incorporated several strategies in Chapter 37 that likewise mitigate adverse selection. These strategies include minimum participation requirements, limited late enrollment, affiliation periods, limited rating criteria, and guaranteed renewal.

- Minimum Participation Requirements—Section 3709(2)[57] allows a carrier to deny coverage if a small employer fails to enroll in that carrier's plan at least a certain percent of its employees who are seeking coverage through the small employer. The maximum allowable percent varies depending on the number of eligible employees. If an employer has 10 or fewer eligible employees, the carrier may require that 100% of the employees seeking coverage through the small employer be enrolled in the plan. For employers with 11 to 25 eligible employees, the maximum permissible requirement is 75% of the employees seeking coverage through the small employer. Employers with 26 to 50 employees may be required to enroll no more than 50% of the employees seeking coverage through the small employer. These minimum participation requirements mitigate adverse selection by reducing or eliminating an

[55] *See, e.g.,* S. Hrg. 108-766, Pauly prepared testimony, p 35.
[56] *See, e.g.,* S. Hrg. 108-766, Pauly prepared testimony, p 35.
[57] MCL 500.3709(2).

employer's ability to concentrate its higher-risk employees into one plan while covering its lower-risk employees in another.[58]

- Limited Late Enrollment—Under section 3708,[59] if an eligible employee or dependent fails initially to enroll in the employer's health benefit plan, he or she may enroll later during a special enrollment period only under limited circumstances. For example, an employee may not enroll in the employer's plan during a special enrollment period unless at the time the plan was previously offered the employee was covered under another health plan and his or her coverage under this plan was exhausted or terminated due to loss of eligibility within the previous 30 days. This limitation on enrollment opportunities creates an incentive for lower-risk employees to enroll in their employer's plan at the first opportunity rather than waiting to enroll until they anticipate needing health care. By encouraging healthy employees to participate, section 3708 mitigates adverse selection.[60]

- Affiliation Periods—Section 3707(2)[61] expressly allows small employer carriers to offer or sell plans that require that up to 60 days must expire before coverage for a new enrollee takes effect. The affiliation period for late enrollees may be no more than 90 days. Requiring an affiliation period helps to mitigate adverse selection because an employee must be healthy enough to work for 60 days in order to qualify for coverage. This requirement screens out high risks who physically cannot work for the 60 days necessary to qualify for coverage. It also tends to discourage sick people from applying for work solely to obtain health benefits because they must work at least 60 days to qualify.[62]

- Limits on Rating Criteria—Rating criteria may have a substantial effect on adverse selection. At one extreme is community rating, where everyone in the plan pays the same premium. Community rating spreads the cost of coverage evenly among everyone in the coverage pool. But because lower risks effectively subsidize higher risks, community rating has the greatest tendency to discourage low-risk persons from participating, thus increasing adverse selection. At the other extreme is proportional risk rating, where everyone in the plan pays a rate tailored to their individual risk. Proportional risk rating

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[58] *See, e.g.*, Exhibit R to Priority Health's declaratory ruling request, "How Private Insurance Works: A Primer" p 6. See also, Attachment A, p 14, "A commercial carrier, then, may not choose to cover 40 healthy employees and leave the 10 sick employees to BCBSM."

[59] MCL 500.3708.

[60] *See, e.g.*, Exhibit R to the Declaratory Ruling Request, "How Private Insurance Works: A Primer," p 6.

[61] MCL 500.3707(2).

[62] S. Hrg. 108-766, Pauly prepared testimony, p 35.

encourages low-risk persons to participate because they pay a lower rate than with community rating. But risk rating increases the costs for higher-risk persons, perhaps to the point of forcing them to drop coverage altogether.[63] Chapter 37 adopts neither of these extremes. It allows all carriers to employ no more than ten geographic areas and to use industry and age to set rates. HMOs may also use group size. Commercial insurers may use industry, age, and group size plus health status.[64] To the extent that Chapter 37 rejects community rating and moves toward allowing carriers to more closely match rates to individual risks, it mitigates adverse selection compared to community rating.

- Guaranteed Renewability—Chapter 37 requires that with certain limited exceptions carriers must renew coverage at the option of the employer.[65] It also generally prevents carriers from billing an employer more for any employee based on that person's individual risk, with some exceptions.[66] Guaranteed renewability at class average premiums mitigates adverse selection because it encourages younger, healthier people to buy the coverage to protect themselves from future premium increases tied to the development of individual chronic illness. Moreover healthier employees are less likely to leave the plan later even if they remain healthy because they have already contributed to the cost of covering those in the group who become higher risks.[67]

There is more than one technique to address adverse selection. Group policies by their very nature provide some protection. In addition, the Legislature incorporated several other strategies into Chapter 37 that mitigate adverse selection. Although Priority Health argues that one of these strategies—minimum participation requirements—is not

[63] S. Hrg. 108-766, Pauly prepared testimony, p 31.
[64] MCL 500.3705(2).
[65] MCL 500.3711.
[66] MCL 500.3705(5).
[67] "[I]t is interesting to note that guaranteed renewability provides potentially important protection against adverse selection. If people buy this coverage early in life (as they should to take advantage of the provision), they are likely to be much more similar in risk levels than they will become later on. And since it is rational for the people who remain healthy to stay in their original policy where they have already made transfers to those in their cohort who became higher risks, it is less likely that they will drop out and start a death spiral." S. Hrg. 108-766, Pauly prepared testimony, p 35.

effective in all cases,[68] Priority Health glosses over the circumstances when it is effective and ignores the multiple other approaches chosen by the Legislature. It is uniquely the province of the Legislature to balance the competing public policy considerations inherent in any particular approach.[69] Perhaps the reason that the Legislature did not expressly permit minimum contribution requirements is that minimum contribution requirements have potential negative effects.

3. Minimum contribution requirements come at a cost. An employer who cannot afford to pay the minimum contribution may therefore be forced to terminate the entire employee benefit plan even though it is willing to contribute a lesser amount and continue the plan.

Priority Health argues that employer contributions make health insurance more available by lowering the out of pocket cost to employees and making them more likely to participate in the plan. Without minimum contribution requirements, they say employers may shift more costs to their employees, causing employees to leave the plan. Priority Health points out that providing health care to the uninsured drives up health care costs for those with insurance and increases the number of persons covered under public programs like Medicaid.[70]

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[68] Priority Health argues that the minimum participation requirements in section 3709 are not effective where an employer offers only one choice of health plan. Declaratory Ruling Request, pp 3 and 10.

[69] "A due regard for the differing functions of the legislative and judicial branches of government requires that the courts refrain from rewriting, under the pretext of interpretation, the clearly expressed language of a legislative enactment which the court deems to be preferable to that which the legislation requires." *Lotoszinski, v. State Farm Mutual Automobile Insurance Company*, 417 Mich 1, 8; 331 NW2d 467 (1980).

[70] Declaratory Ruling Request, pp 4-9.

But Priority Health does not acknowledge that minimum contribution requirements may actually increase the number of uninsured persons. What happens if an employer is no longer able to contribute the minimum amounts due to ever-rising health care costs? If the minimum contribution is 50% of the cost and the employer can no longer contribute at that level, then the employer cannot continue the plan even if, for example, it were willing to contribute 40%. Thus the minimum contribution requirement could easily cause an employer to discontinue its plan altogether despite the fact that:

- The employer is willing to make a substantial contribution less than the minimum amount;
- The employees prefer to keep the program in spite of the higher costs because individual coverage is less desirable; and
- Together the employer and its employees are offering to pay the carrier 100% of the required premium.

In light of this possible negative consequence, are minimum contribution requirements really desirable public policy overall as Priority Health argues? It is the Legislature's prerogative to make this judgment, balancing the potential advantages with the potential disadvantages. The Legislature made this decision when, as described in section II.E. above, it eliminated proposed language in section 3711(2) that would have allowed carriers to refuse to renew coverage based on the failure to satisfy minimum contribution requirements. Instead, the Legislature mandated that the carriers must continue coverage at the employer's option without regard to the level, if any, of the employer's contribution to the cost. Apparently the Legislature was satisfied that it adequately addressed the threat of adverse selection through the other strategies it expressly adopted, including minimum participation requirements, limited late

enrollment, affiliation periods, limits on rating criteria, and guaranteed renewal. Whether on balance this is desirable public policy is a legislative decision.

4. Although carriers may not impose minimum contribution requirements under Chapter 37, carriers may still charge appropriate rates and otherwise compete with other small employer carriers in this market.

The prohibition on minimum employer contribution requirements applies uniformly to commercial insurers, HMOs, and nonprofit health care corporations that write coverage for small employer groups. Chapter 37 does not require carriers to write this coverage below cost. The limitations in Chapter 37 on rating this business only affect how the costs are distributed among all those insured under a small employer plan in a geographic territory. Priority Health has made no allegation that carriers cannot operate profitably without imposing minimum contribution requirements. Priority Health only argues, incorrectly, that minimum contribution requirements are allowed by Chapter 37 and are good public policy. But minimum contribution requirements are not allowed by Chapter 37 and whether they would be good public policy is a question for the Legislature.

III.
Ruling

For the reasons explained above, the Commissioner of the Office of Financial and Insurance Services concludes and declares that:

1. Under Chapter 37 of the Insurance Code, MCL 500.3701 *et seq.*, a small employer carrier may not refuse to issue or renew any health benefit plan it markets to small employers in this state on the grounds that a small employer fails to contribute a

minimum portion of the cost of the coverage. A small employer carrier may not require a small employer to contribute any amount to the cost of the coverage provided the employer agrees to make the full premium payment to the carrier, without regard to the ultimate source of the funds.

2. Section 3707(1), MCL 500.3707(1), requires a carrier to make its small employer plans available to each small employer who applies and agrees to make the payments, subject only to reasonable conditions not inconsistent with Chapter 37. It is unreasonable and inconsistent with Chapter 37 for a carrier to initially deny coverage on the grounds that an employer does not make a minimum contribution because section 3711, MCL 500.3711, requires every carrier to renew coverage without regard to whether an employer contributes. Therefore Priority Health's minimum contribution requirement is prohibited by section 3707(1) because it is unreasonable and inconsistent with section 3711.

3. In Chapter 37 the Legislature struck a balance between competing public policy considerations. It explicitly adopted some strategies for dealing with adverse selection and rejected or limited others. Neither the Executive Branch nor the Judicial Branch of government may usurp the Legislature's prerogative in the guise of interpreting the clear language of Chapter 37.

Linda A. Watters
Commissioner

IV
LIST OF ATTACHMENTS

Attachment A—Senate Fiscal Agency, Bill Analysis, Senate Bills 234, 238, and 460 (as enrolled) and House Bills 4280 and 4281 (as enrolled), September 17, 2003.

Attachment B—Prepared statement of Mark V. Pauly, PhD, Bendheim Professor, Professor of Health Care Systems, Insurance and Risk Management and Business and Public Policy in the Wharton School, and Professor of Economics in the College of Arts and Sciences, University of Pennsylvania before the Joint Economic Committee, Congress of the United States, 108th Cong., 2d sess., 31 (2004).

Attachment C—Senate Bill No. 460 as introduced in the Senate on May 7, 2003.

Attachment D—Substitute for Senate Bill No. 460 as it passed the Senate on May 28, 2003.

Attachment E—House substitute for Senate Bill No. 460 as it passed the House on June 5, 2003.

Attachment F—Summary from the Michigan Legislature's web page tracking the course of Senate Bill 460 through the Senate and House (http://www.legislature.mi.gov/(hxtnii45v4avzazbul5qpj3b)/mileg.aspx?page=getObject&objectName=2003-SB-0460).

Attachment G—The final version of Senate Bill No. 460 (2003 PA 88) that became law.